112. INTERIM RATE FOR NEW FACILITIES

For facilities newly constructed and open for business within twelve (12) months prior to date of entry into the Medicaid Program, and for other facilities initially entering the Medicaid Program, the initial payment shall be based on a temporary rate. The temporary rate shall be computed using a sum of a nursing services cost component, the applicable all other cost per diem upper limit, and other applicable allowances used in the current rate year. The nursing services cost component shall consist of the applicable nursing services cost per case mix unit upper limit multiplied by the case mix weight for the facility as established by the most recent case mix assessment until the facility is assessed, the case mix utilized to the temporary interim shall be statewide average for all facilities during the most recent assessment quarter. The upper limits used shall depend on the facility's urban or rural classification. The rate is not subject to the occupancy factors. Hospital-based nursing facilities shall receive a temporary rate using the applicable hospital-based upper limits. The temporary rate shall be recalculated quarterly.

If the rate has been determined on the basis of an audited cost report containing twelve (12) months of actual data in the fiscal year, payments shall be subject to settlement based on audited cost data.

112. INTERIM RATE FOR NEW FACILITIES

An ancillary settlement shall be made on the basis of an audited cost report based on the facility's fiscal year.

At the end of the first full facility fiscal year, the following procedure shall be utilized to yield a modified occupancy rate for setting the prospective rate for the next fiscal year. This modified occupancy rate is to be derived from the average occupancy rate for the facility's last quarter of the first full facility fiscal year and averaging this rate with ninety (90) percent occupancy in the facility. The derived rate shall be applied to the total allowable costs of the second full facility fiscal year in order to determine the per diem rate to be allowed for that fiscal year. If the referenced last quarter's occupancy rate is above ninety (90) percent, the general occupancy rate shall be imposed for subsequent rate setting period.

114. PAYMENT OF SPECIAL PROGRAM CLASSES

A. STATE DEFINED DUAL LICENSED ACUTE CARE BEDS. Pursuant to legislation enacted by the 1986 General Assembly, a licensed acute care hospital may obtain a dual license for twenty-five (25) licensed acute care beds or ten (10) percent of the hospital's total licensed acute care bed capacity, whichever is greater, but shall not exceed forty (40) percent of the hospital's total licensed acute care bed capacity, to provide nursing facility care in these beds.

The Medicaid Program shall reimburse acute care hospitals for nursing facility services provided to patients placed in dual licensed beds. The reimbursement rate for routine services for dual licensed beds shall be the appropriate urban or rural upper limits for hospital-based nursing facilities, taking into account the facility's average case mix weight, plus any additional rate allowances added on to other nursing facilities' rates, except that dual licensed beds shall not be eligible for the rate adjustments provided for in Section 110 and 111 of this manual. The hospital shall submit a separate cost report for nursing facility services.

114. PAYMENT OF SPECIAL PROGRAM CLASSES

B. FEDERALLY DEFINED SWING BEDS. Federally defined swing services beds shall be reimbursed by the Medicaid Program at the weighted average payment rate for routine services for the prior calendar year for all nursing facilities in the state.

C. ANCILLARY SERVICES FOR DUAL LICENSED AND SWING BEDS. Payments for reimbursable ancillary services provided to nursing facility patients in dual licensed or swing beds shall be based on a percent of charges with a settlement to the lower of actual cost or charges at the end of the facility's fiscal year. Ancillary services covered shall be the same ancillary services as are covered in the regular nursing facility setting.

Swing bed facilities shall be required to file Schedules A, D-5, D-6, D-7, as well as the ancillary portion of Schedule F of the Nursing Facility Cost Report to the Long-Term Care Reimbursement Branch. Dual licensed bed facilities shall be required to file Schedules A, D-5, and E as well as the ancillary portion of Schedule F of the Nursing Facility Cost Report, as well as Supplemental Medicaid Schedules Nursing-2 and Nursing-3.

114. PAYMENT OF SPECIAL PROGRAM CLASSES

D. HEAD INJURY UNITS. Facilities which are Medicaid certified Head Injury Units providing preauthorized rehabilitation services for persons with brain injuries shall be reimbursed their usual and customary charges up to an all-inclusive rate of $360.00 per diem (excluding drugs which shall be reimbursed through the pharmacy program). These units shall be excluded from the nursing facility arrays.

Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae shall be paid on all-inclusive (excluding drugs) negotiated rate which shall not exceed the facilities' usual and customary charges.

114. PAYMENT OF SPECIAL PROGRAM CLASSES

E. CARE NEEDS ASSOCIATED WITH INFECTIOUS DISEASES.

Effective October 1, 1990, a special access and treatment fee shall be paid to Nursing Facilities caring for residents with care needs associated with highly infectious or communicable diseases with limited treatment potential, such as:

Hepatitis B

Methicillin-Resistant Staphylococcus Aureus (MRSA)

Acquired Immune Deficiency Syndrome - AIDS

Human Immunodeficiency Virus (HIV) Positive

The special access and treatment fee of ten (10) dollars per diem shall be added to the CMAR per diem rate for each resident determined to qualify by the peer review organization.

Ancillary services for these residents shall be paid in accordance with policies outlined in the General Policies and Guidelines.

F. VENTILATOR FACILITIES.

Facilities recognized as providing ventilator dependent care shall be paid at an all-inclusive fixed rate (excluding drugs which shall be reimbursed through the pharmacy program). A distinct part unit of not less than twenty (20) beds shall be required and the facility shall have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter

114. PAYMENT OF SPECIAL PROGRAM CLASSES

preceding the beginning of the rate year, or the quarter preceding the calendar quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The fixed rate for hospital-based facilities shall be four hundred and sixty (460) dollars per day, and the fixed rate for freestanding facilities shall be two hundred and fifty (250) dollars per day. The rates shall be increased based on the Data Resources, Inc. rate of inflation indicator for the nursing facility services for each rate year beginning with the July 1, 1997 rate year. Cost of such distinct part units shall be excluded from allowable cost for purposes of rate setting and settlement.

Reimbursement for patients who occupy ventilator distinct part beds but do not meet ventilator care status as defined in the Nursing Facility Services Manual, shall be made pursuant to Section 115.01 of this manual..

115. PAYMENT FOR ANCILLARY SERVICES

The reasonable, allowable, direct cost of ancillary services as defined provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate and shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost and charge ratios for ancillary services. These ratios shall be limited to one hundred (100) percent and each request shall be analyzed by Department for Medicaid Services staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Medicaid Program charges to total charges applied to direct departmental costs.

A retroactive settlement between actual direct allowable costs and actual payment made by the Department for Medicaid Services shall be made at the end of the accounting period based on the facility's annual Cost Report.

Indirect ancillary costs shall be included in routine cost and reimbursed through the prospective rate.

TN # 96-10 Approved MAY 16 2001 Eff. Date 7-1-96
Supersedes
TN # 90-6

116. RETROACTIVE ADJUSTMENT FOR ROUTINE SERVICES

A. A retroactive adjustment may be made for routine services in the following circumstances:

1. If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data does not constitute a computational error.

2. If a determination is made by the Department for Medicaid Services of misrepresentation on the part of the provider.

3. If a facility is sold and the funded depreciation account is not transferred to the purchaser.

4. If the prospective rate has been set based on an unaudited cost report and the prospective rate is adjusted based on a desk review or field audit. The appropriate cost settlement shall be made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.

116. RETROACTIVE ADJUSTMENT FOR ROUTINE SERVICES

If adjustments are necessary, any amounts owed the provider shall be paid by the Department for Medicaid Services. Any amounts owed the Department for Medicaid Services shall be paid in cash or recouped by a reduction of the payment rate during the remainder of the reporting year.

B. BANKRUPTCY OR INSOLVENCY OF PROVIDER. If, on the basis of reliable evidence, the Department for Medicaid Services has a valid basis for believing that, with respect to a provider, proceedings have been or may shortly be instituted in a State or Federal court for purposes of determining whether the facility is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the Department for Medicaid Services notwithstanding any other reimbursement principle or Department for Medicaid Services instruction regarding the timing or manner of adjustments, to a level necessary to insure that no overpayment to the provider is made. This section shall be applicable only to ancillary services.

117. RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES

A. Actual cost reimbursable to a provider shall not be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment shall be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the ancillary services rendered to the Department for Medicaid Services recipients during that period.

B. In order to reimburse the provider as quickly as possible, a partial retroactive adjustment may be made when the cost report is received. For this purpose, the costs shall be accepted as reported unless there are obvious errors or inconsistencies subject to later audit. When an audit is made and the final liability of the Department for Medicaid Services is determined, a final adjustment shall be made.

C. To determine the retroactive adjustment, the amount of the provider's total allowable ancillary cost apportioned to the Department for Medicaid Services for the reporting year is computed. This is the total amount of the reimbursement the provider is due to receive from the Department for Medicaid Services

117. RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES

for covered ancillary services rendered during the reporting period. The total of the interim payments made by the Medicaid Program in the reporting year is computed. The difference between the reimbursement due and the payments made shall be the amount of retroactive adjustment.

D. ANCILLARY SERVICES. Upon receipt of the facility's cost report, the Department for Medicaid Services shall as expeditiously as possible analyze the report and commence any necessary audit of the report. Following receipt and analysis of any audit findings pertaining to the report, the Department for Medicaid Services shall furnish the facility a written notice of amount of Medicaid reimbursement. The notice shall (1) explain the Department for Medicaid Services's determination of total Medicaid reimbursement due the facility for the reporting period covered by the cost report or amended cost report; (2) relate this determination to the facility's claimed total reimbursable costs for this period; and (3) explain the amount(s) and the reason(s) for the determination through appropriate reference to the Department for Medicaid Services policy and procedures and the principles of reimbursement. This determination may differ from the facility's claim.

117. RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES

The Department for Medicaid Services' determination as contained in a notice of amount of Medicaid reimbursement shall constitute the basis for making the retroactive adjustment to any Medicaid payments for ancillary services made to the facility during the period to which the determination applies, including the suspending of further payments to the facility in order to recover, or to aid in the recovery of, any overpayment determined to have been made to the facility.

E. ROUTINE SERVICES. When a retroactive adjustment is made to the routine rate, the Fiscal Agent shall adjust all routine payments made based on the rate which was adjusted.

119. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID PATIENTS

A. PRINCIPLE. When a patient is eligible for medical coverage under both the Title XVIII (Medicare) Program and theMedicaid Program, the facility participates in both programs, and a day of care is a Medicare covered day, the patient shall be considered to be a Medicare patient for purposes of this reimbursement system.

B. APPLICATION. Services received by a patient which are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Nursing Facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Co-insurance and deductible payments shall be based on rates set by the Medicare Program. A day of service covered in this manner shall be considered a Medicare patient day and shall not be included as a Medicaid patient day in the facility cost report.

TN # 96-10 Approved MAY 16 2001 Eff. Date 7-1-96
Supersedes
TN # 90-6

120. RETURN ON EQUITY OF PROPRIETARY PROVIDERS

An allowance for a return on equity capital invested and used in the provision of patient care shall not be allowed. In lieu of a return on equity, the Medicaid Program provides the Cost Savings Incentive factor.

121. DESK REVIEW AND FIELD AUDIT FUNCTION

After the facility has submitted the annual cost report, the Division of Reimbursement Operations shall perform an initial "desk review" of the report. During the desk review process, Medicaid staff shall subject the submitted Cost Report to various tests for clerical accuracy and reasonableness. If the Medicaid Program detects clerical error, the Department for Medicaid Services shall return the submitted Cost Report to the provider for correction. If Medicaid staff suspect possible errors rather than simple clerical errors, the Medicaid staff shall require the provider to submit supporting documentation to clarify any areas brought into question during the desk review. The desk review shall not be deemed to be completed until all clerical errors have been rectified and all questions asked of the provider during the desk review process have been answered fully. Additionally, results of this desk review shall be used to determine whether a field audit, if any, is to be performed. The desk review and field audits shall be conducted for purposes of verifying prior year cost to be used in setting prospective rates which have been set based on unaudited data. Ancillary service cost shall be subject to the same desk review and field audit procedure to settle prior year costs.

121. DESK REVIEW AND FIELD AUDIT FUNCTION

121. DESK REVIEW AND FIELD AUDIT FUNCTION

The field audit procedures shall include an audit of Patient Fund Accounts to insure the Medicaid Program that the providers are in compliance with appropriate federal and state regulations.

122. REIMBURSEMENT REVIEW

Participating facilities are provided a mechanism for a review of the Department for Medicaid Services decisions relating to the application of the policies and procedures governing the Case Mix Assessment Reimbursement system. The request for a review or reconsideration shall be submitted in accordance with the requirements set forth in Sections 12 and 14 of 907 KAR 1:671.

COMMONWEALTH OF KENTUCKY
Cabinet for Health Services
Department for Medicaid Services

Department for Medicaid Services
NURSING FACILITY PAYMENT SYSTEM

PART II
NURSING ASSESSMENT

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200. INTRODUCTION TO THE CASE MIX ASSESSMENT PROCESS

A. THE ASSESSMENT PROCESS. The resident assessments used to compute a facility's average case mix weight shall be completed by Peer Review Organization's Registered Nurses. Assessments shall reflect the resident's condition on a date assigned by the reviewer to be the target date. The assessment shall be based on a review of the resident's medical record. The Peer Review Registered Nurses or Coordinators shall physically observe the resident to determine if the resident's medical record is congruent with the mental status and physical condition of the resident.

B. FREQUENCY OF ASSESSMENT. During each assessment quarter, the Peer Review Organization (PRO) contractor shall assess all Nursing Facilities which participate in the Kentucky Medicaid Program. Assessment quarters are as follows: December through February, March through May, June through August, and September through November.

C. SCOPE OF ASSESSMENTS. The PRO contractor shall assess all residents including hospice patients for whom Medicaid is the primary payor or co-insurer of benefits who are either present in the facility or on leave on the target date.

TN # 96-10 Approved MAY 1 6 2001 Eff. Date 7-1-96
Supersedes
TN # 91-19

200. INTRODUCTION TO THE CASE MIX ASSESSMENT PROCESS

The facility shall be responsible for providing a complete list of Medicaid residents to the reviewer. This list shall include all residents who receive Medicaid benefits for any portion of their stay and all those in pending Medicaid status.

D. FEEDBACK FROM ASSESSMENTS.

The reviewer shall hold an exit conference upon completion of the facility case mix review. At this time, the reviewer shall provide information relating to the assessments. Participation of the facility administrator or Director of Nursing in these conferences promotes a better understanding of the system and process.

E. ASSESSMENT APPEAL PROCESS

1. Reconsideration by the PRO. If the provider disagrees with any of the resident assessments performed by the PRO contractor and would desire to have the PRO contractor reconsider the assessment classification, the provider shall notify the PRO contractor in writing of their desire to have the assessment classification(s) reconsidered. This request for reconsideration shall be postmarked within seven (7)

days of the provider having been informed of the original assessment by the PRO.

Requests for reconsideration shall be made on Medicaid form -575.

This form shall be filled out completely including an explanation as to the reasons for asking that the classification be reconsidered. The provider shall also attach a copy of the original assessment with areas of disagreement circled and copies of any documentation which shall support their request for reconsideration.

No reconsideration shall be made unless the item(s) being contested have the potential of changing the resident's overall classification. Requests for reconsideration which are based upon disagreement with case mix policy only shall not be considered by the PRO contractor but shall be referred to the Department for Medicaid Services.

If the review agency receives a properly filed request for reconsideration, the PRO shall conduct a second assessment of the resident within seven (7) days of the receipt of the request. The PRO staff conducting the reconsideration shall not include anyone who

participated in the original assessment. Copies of the assessments completed during the reconsideration process shall be given to the provider at the completion of the reconsideration process. The reconsideration shall be limited to those factors having a bearing on the resident's classification.

The assessment performed during the reconsideration process shall be used in lieu of the original assessment. This is regardless of whether the second assessment is higher or lower than the first assessment.

2. Appeal to the Assessment Review Panel. If, after the reconsideration of the assessment(s) by the PRO, the provider does not agree with the assessment(s) performed by the PRO, the provider may appeal the assessments to the Assessment Review Panel if the following conditions are met:

   a. The appeal is made in writing and is postmarked within thirty (30) days of the completion of the reconsideration.

b. The request explains in detail the reason for the appeal for each assessment being appealed. Copies from the medical record to support this request shall be included.

c. The provider has properly utilized the reconsideration process available through the PRO for the assessment area being appealed.

d. The assessment(s) being appealed have the potential of changing the provider's average case mix weight by .01 or more for that particular quarter.

The Assessment Review Panel shall be chaired by the Director of the Division of Program Services or the Director's designee. The remaining two (2) members shall be registered nurses. One (1) of the registered nurses shall be an employee of the Department for Medicaid Services. The other registered nurse shall be an individual from the Nursing Facility industry.

A date for the Assessment Review Panel to convene shall be established within twenty (20) days of the receipt of a written request for an appeal. The Panel shall issue a binding decision on the appealed assessments within thirty (30) days of the hearing. These time frames may be waived by mutual consent of the provider and the Panel.

F. Quality Assurance

The Department for Medicaid Services has established a Case Mix Quality Assurance Program. The Quality Assurance staff members are registered nurses who perform a sample of resident assessments in the wake of the PRO reviewers. Problems discovered by the sampling strategy are brought to the PRO's attention for appropriate corrective action. Resident assessments performed by the Medicaid Quality Assurance staff shall not, however, directly change individual assessments performed by the PRO reviewers.

201. RESIDENT ASSESSMENT

A. ELEVEN (11) ASSESSMENT STANDARDS USED TO DETERMINE CLASSIFICATION AND REIMBURSEMENT. Under the CMAR system, eleven (11) assessment standards affect classification and reimbursement. These standards reflect the care needs of the resident. The items are eight (8) Key Activities of Daily Living (ADL), and three (3) additional variables which are Behavior, Special Nursing Treatments, and Clinical Monitoring.

B. CRITERIA FOR EIGHT (8) KEY ACTIVITIES OF DAILY LIVING. In order to determine the proper score under an Individual Dependency, the resident's medical record shall establish that within twenty-one (21) days of a new admission or following a significant change in resident condition requiring a Minimum Date Set (MDS) reassessment, the three (3) criteria listed below shall be met in their entirety. If the following three (3) criteria are not met, the client shall be assigned a score of "0" (independent) in all eight (8) ADLs except for those residents exempted by Section 204:

1. The physician has performed a medical evaluation of the resident. A physician evaluation may take many forms. Some examples are history and physical records, progress notes stating the exam was completed, a note by the doctor on a hospital

201. RESIDENT ASSESSMENT

discharge summary stating that it is accepted as the evaluation or an exam from a previous admission which has a statement by the physician stating it is acceptable as the current evaluation.

2. A registered nurse has coordinated a resident assessment;

A registered nurse shall not be obligated to specifically perform all aspects of the resident assessment, however, a registered nurse shall, at a minimum, coordinate the various portions of the assessment which are performed by other staff, and shall sign the assessment, thereby attesting to the coordination and oversight. Nursing assessments which are performed to meet the requirements of the MDS system shall also fulfill the nursing assessment requirements of the case mix system. If the resident was admitted prior to October 1, 1990, and a licensed practical nurse performed the assessment without a registered nurse's coordination, this shall constitute an acceptable nursing assessment until the MDS system is fully implemented.